BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Statement of Issues Against:	Case No. 800-2017-038695
ANDREW NAM CAI,	OAH No. 2019010010
Respondent.	

DECISION AFTER NON-ADOPTION

Administrative Law Judge (ALJ) Tiffany L. King, Office of Administrative Hearings, State of California, heard this matter on July 10, 2018, in Sacramento, California.

David Carr, Deputy Attorney General (DAG), represented Kimberly Kirchmeyer (Complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs, State of California.

Paul Chan, Attorney at Law, represented Andrew Cai (Respondent), who was present.

Evidence was received, the record was closed, and the matter was submitted for decision on July 10, 2018.

On October 30, 2018, Panel A of the Board issued an Order of Non-Adoption of Proposed Decision. Oral argument on the matter was heard by the Panel on January 31, 2019, with ALJ Jill Schlichtmann presiding. Complainant was represented by DAG Carr. Respondent was present, and was represented by Dominique Pollara, Attorney at Law. Panel A, having read and considered the entire record, including the transcripts and the exhibits, and having considered the written and oral arguments presented by Respondent and Complainant, hereby makes and enters this decision on the matter.

FACTUAL FINDINGS

1. On June 6, 2017, Respondent filed an application for a physician's and surgeon's certificate with the Board. The Board denied the application on November 13, 2017. Respondent timely filed a notice of defense, requesting an administrative hearing. On March 12, 2018, Complainant brought the instant Statement of Issues solely in her official capacity.

Respondent's Licensure Application

2. Question 31 on the application, concerning postgraduate training, asked: "Were any limitations or special requirements imposed on you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?" Respondent answered, "No." He signed the application, certifying under penalty of perjury that all of the information listed therein was true and correct.

3. On or about July 3, 2017, in connection with Respondent's application, the Board received a Certificate of Completion of ACGME/RCPSC[1] Postgraduate Training, completed by David A. Fuller, M.D., Program Director of the Orthopaedic Surgery Program (Program) at Cooper University Hospital (Cooper) in Camden, New Jersey. In the section entitled "Unusual Circumstances," Dr. Fuller answered "Yes" to the following question:

> Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems, or for any other reason?

In a cover letter dated June 30, 2017, Dr. Fuller explained that, during his first year at Cooper, Respondent had been subject to "conditions or restrictions beyond those generally associated with the training regimen" for the Program. Dr. Fuller continued that Respondent "demonstrated professional and communication deficiencies during his first six months in the program." He explained:

> . . . [Respondent] struggled with attention to detail, careful reporting of activities, time management skills and understanding the time commitment and focus required to succeed in the program. He was placed on a performance improvement plan to address these issues. Evaluations during the performance improvement plan indicated some evidence of improvement. [Respondent] concluded that he wished to pursue a different program and voluntarily resigned his position in the residency program [for second year of residency] before completion of the first year.
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> [Respondent] did finish the [first] year with some modifications to his program, and is credited with completion of his PGY1 year. [Respondent] did demonstrate personal growth and maturation through the year.

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[1] ACGME stands for Accreditation Council for Graduate Medical Education. RCPSC stands for Royal College of Physicians and Surgeons of Canada.

Residency at Cooper

4. Respondent began his first year of a five-year residency program in orthopaedic surgery at Cooper on July 1, 2016. Dr. Fuller was the Program Director. Vishal Khatri, M.D., was the Chief Resident.

5. From the outset, Respondent struggled with the rigorous demands of residency. Dr. Khatri and others expressed concerns to Dr. Fuller regarding Respondent's communication, documentation, patient care, failing to discuss patient consultations with attending physicians or senior residents, failing to complete his assignments, and not seeking guidance or assistance.

6. In late August 2016, Dr. Fuller met with Respondent and discussed the concerns of other residents and faculty regarding his performance, specifically Respondent's ability to follow instructions and perform patient consultations. Dr. Fuller gave an example in which Respondent asked for Dr. Fuller's treatment recommendation for a pediatric patient with a humerus fracture. It was evident to Dr. Fuller that Respondent had neither reviewed the x-rays nor seen the patient prior to consulting with him.

ACTION PLAN

7. On September 30, 2016, Dr. Fuller again met with Respondent and advised him there were continuing concerns regarding his performance. Dr. Fuller provided Respondent a formal, written "Action Plan" to address these deficiencies. The Action Plan included well-defined clinical expectations, a more limited scope of practice, closer evaluation of Respondent's work, and weekly feedback. It also included learning modules consisting of reading materials, videos, and other available references. Dr. Fuller advised Respondent that if his performance did not improve, he risked being placed on probation, nonrenewal of his contract, and termination. The Action Plan took effect on October 3, 2016, and was to last one month.

8. Dr. Fuller and Respondent next met on October 11, 2016. Dr. Fuller asked Respondent if he had viewed the videos for the Splinting Module. Respondent replied that he had. Dr. Fuller then asked him specific questions about the video, including, who was the instructor, what demonstrations were shown, etc. Based on Respondent's answers, Dr. Fuller concluded that Respondent had not watched the video. When he confronted Respondent, he asserted he had had difficulties playing the video on the computer.

9. On October 13, 2016, the Action Plan was modified due to "persistent deficiencies." Among other things, these modifications required Respondent to contact a senior resident before evaluating a patient, and to review all consults with an attending physician prior to documenting the patient's medical chart.

PERFORMANCE IMPROVEMENT PLAN

10. By letter dated October 25, 2016, Dr. Fuller notified Respondent that the Action Plan was being supplanted by a performance improvement plan (PIP) designed to

improve his performance in one or more ACGME competencies. The letter identified academic deficiencies in six competencies (Professionalism, System Based Practice, Patient Care, Medical Knowledge, Communication, and Practice Based Learning), specifically, that Respondent failed to:

(1) perform assigned tasks;
(2) follow instruction;
(3) competently perform histories and physicals, develop appropriate plans;
(4) follow through with stated work plans;
(5) triage patient care issues;
(6) work efficiently and balance multiple tasks;
(7) present consults well;
(8) document well (accuracy, timeliness);
(9) anticipate patient care needs and function proactively; and
(10) understand and acknowledge own deficiencies.

Additionally, under Professionalism, Communication, and System Based Practice, the letter characterized Respondent's conduct as "Unethical Conduct – failure to speak honestly (lying)". Specific examples of Respondent's academic deficiencies and alleged misconduct were attached.

Under "Interpersonal and Communication Skills Goals," the letter stated:

> In relation to all of the above, [Respondent] needs to listen to advice and feedback. [Respondent] needs to speak truthfully. [Respondent] needs to stop lying. [Respondent] needs to speak clearly with others. [Respondent] needs to be accountable for his actions and to learn to answer with a yes or no when asked direct questions. [Respondent] needs to communicate better with his supervising senior residents and faculty.

Under "Professionalism Goals," the letter provided:

> In relation to all of the above, [Respondent] needs to behave as a person that cares about what he is doing. He needs to work with integrity. He needs to understand that his failings have direct impact upon patients. He needs to take responsibility for his actions. He needs to learn to apologize. He needs to learn to stop making excuses. He needs to document his performance activities in a truthful, timely and thorough manner. [Respondent] must respond to communications from his faculty and administrators in a timely fashion.

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11. The letter also identified a "Plan of Remediation," which included "scholarly assignments, a restricted scope of practice with limited patient care expectations to preserve patient safety and regular feedback." Additionally, Respondent was to meet with external specialists, including a learning specialist and work performance counselors.

12. The letter advised that Respondent would be placed on the PIP for 60 days, beginning November 1, 2016. At the conclusion of the PIP, a decision would be made concerning Respondent's continued participation in the residency program and employment at Cooper. Finally, the letter noted, "[t]his decision may involve successful completion of the PIP and continuation in the program, continuation in the program on probationary status, suspension or termination (dismissal)."

13. Respondent submitted a written response to the PIP on or about October 31, 2016. In it, Respondent admitted to exhibiting deficiencies in triaging patient care, presentation of patient consultations, efficiency, and multi-tasking. He disagreed with the remaining identified deficiencies. In addition, he refuted the notion that he was generally dishonest. However, he admitted that he had not watched the training videos and nonetheless implied to Dr. Fuller that he had. He also acknowledged communicating inaccurate information to his team; however, he denied any intent to lie or deceive. Rather, he explained, "[a]fter self-reflecting my time at Cooper, I found that I was not able to recall information correctly due to my lack of organization and focus (not deception)."

14. While the PIP remained in effect, communications between faculty and Dr. Fuller evidenced ongoing concerns regarding Respondent's adherence to the requirement he consult with an attending physician prior to documenting care in a patient's medical chart. In a December 5, 2016 note, Dr. Fuller described an incident reported to him in which Respondent verbally asserted he had consulted with the attending physician prior to documenting the chart; however, his chart note made no reference to having consulted an attending physician. The attending physician also had no recollection of discussing the patient with Respondent. Dr. Fuller concluded, " . . . [a]ll evidence suggests that [Respondent] is lying again."

15. Evaluations of Respondent's performance immediately prior to and during the PIP indicated some improvement. For instance, one reviewer noted that Respondent had "struggled early . . . but has improved the last 2 weeks." Another reviewer commented that, during his vascular surgery rotation, Respondent was "attentive and focused" and "[f]it in well with our team." Still, other evaluators remained concerned about Respondent's work ethic, honesty, and ability to perform at the level expected of first-year residents. One reviewer commented that Respondent "[needs] to work harder. Has lost trust of fellow residents. Needs to work harder to regain trust of the team." Another reviewer noted on December 27, 2016:

> [Respondent] was a friendly intern who came to work with a good attitude. He appeared to have significant deficits with regards to his general understanding of his duties. His level of function was closer to a starting intern than a seasoned one in

mid-year form. He frequently required significant guidance for basic floor tasks and the senior residents and fellows felt the need to prioritize his daily tasks in order to assure that the most pressing issues were completed in a timely fashion.

16. Respondent completed the PIP on December 31, 2016. The PIP was not renewed and Respondent returned to his normal resident schedule. On February 20, 2017, Respondent informed Dr. Fuller of his intent to resign after the completion of his first residency year with credit and to not return for his second year.

17. Respondent completed the remainder of his first year residency without incident. His performance evaluations were mixed, but overall reflected that Respondent's maturity and confidence had grown, and his efficiency improved. Respondent received credit for 12 months of postgraduate residency training, and thereafter voluntarily resigned from the Program.[2]

UC Davis Job Offer

18. After resigning from the Program, Respondent and his wife relocated to California. In August 2017, Respondent was offered a non-ACGME accredited Junior Specialist position in the Department of Orthopedic Surgery at UC Davis Medical Center. As described by Respondent, his role would be "to act as an attending hospitalist and consultant for incoming ER patients during daytime hours for the Orthopaedic Trauma Service" and provide a physician presence in the emergency room and Orthopaedic Surgical Intensive Care Unit. The position requires Respondent to have a valid California medical license.

Joseph Silva, M.D.

19. Complainant called Joseph Silva, M.D., as an expert witness. Dr. Silva has been licensed to practice medicine in California since 1983. Previously, he was licensed to practice medicine in Maryland (1968-1969) and Michigan (1969-1983). He has been board- certified in internal medicine since 1972. From 1972 to 1985, Dr. Silva served as the Program Director of Internal Medicine at the University of Michigan Medical School, overseeing more than 140 residents and 100 post-doctoral fellows. Thereafter, he was a professor and Chairman of Medicine at the University of California, Davis (UC Davis) for 15 years, teaching internal medicine and family medicine. In 1997, he became the Dean of the UC Davis School of Medicine and Chief Executive Officer of the UC Davis Health Systems. In 2005, Dr. Silva stepped down as Dean and became a dean emeritus, periodically teaching internal medicine and infectious diseases. Over the course of his career, Dr. Silva has performed functions similar to those of the Program Director of Cooper. He has had extensive opportunities to evaluate residents and to prepare performance evaluation reports on residents, which are structured to address ACGME's core competencies. In 2010, Dr. Silva was a consultant to California Northstate University to establish a new medical school. From 2015 to present, he has served

[2] There was no evidence to suggest that Respondent's resignation was offered in exchange for leaving the program and/or receiving full credit for his first year residency.

as the Founding Dean, Vice President for Medical Affairs, and Professor of California Northstate University, College of Medicine. Since 2010, Dr. Silva has served as a medical consultant to the Board.

20. At the Board's request, Dr. Silva reviewed Respondent's license application as well as the transcripts and certification of his medical education. Dr. Silva also reviewed the Certificate of Completion of ACGME/RCPSC Postgraduate Training completed by Dr. Fuller, and records from Respondent's participation in the Program at Cooper. Based on these records, Dr. Silva noted that Respondent "had a number of problems in learning that subspecialty and demonstrating performance satisfactory to a number of faculty," and that those difficulties continued while Respondent was on the Action Plan and PIP.

21. Dr. Silva explained it was not unusual for a resident who was successful in medical school to be unsuccessful in residency. He noted that residents are subject to a greater level of scrutiny than medical students. If there are deficiencies in a resident's performance, the program will develop an action plan, PIP, or probation plan to overcome them. Such plans are often successful. Dr. Silva explained, "these are good people, intelligent, capable, but not putting it all together." Still, there were very few programs in the country where one can become licensed after completing just one year of residency.

22. Dr. Silva noted that Respondent's Action Plan and PIP at Cooper comprised a multi-prong approach to help Respondent gain the necessary skills to advance. This included: limiting his scope of patient practice; requiring Respondent to meet weekly with faculty for feedback, when the standard is monthly; meeting with specialists; scholarly assignments; and, "over a hundred pages of deliberations and evaluation materials by the program director and his faculty in documenting new and/or chronic performance deficiencies." Dr. Silva opined that the PIP was "sequentially designed" to give Respondent "less independence in patient care decisions . . . and greater supervision because he had failed to meet training expectations on multiple occasions."

23. Dr. Silva reviewed the academic deficiencies in core competencies as identified in the PIP, and opined that these deficiencies would "hinder a doctor's ability to render effective and safer care to patients." Dr. Silva did not render an opinion regarding the allegations of dishonesty, but noted that faculty had raised concerns about Respondent's truthfulness more than once. Dr. Silva further noted that, while Respondent was credited for one year of training, he did so with "conditions or restrictions beyond those generally associated with the training program at that facility." Based on this, Dr. Silva opined that Respondent "has multiple deficiencies in rendering safe and effective care . . . [and] has not demonstrated he has mastered the basic essentials and proficiencies required of all physicians to practice medicine."

Respondent's Evidence

24. Respondent graduated from Tufts University, earning a bachelor's degree in chemistry in 2008, and a master's degree in biomedical sciences in 2011. He obtained his doctorate in medicine from Albany Medical College in 2016. He is not currently licensed as a

physician in any state.

25. Respondent's parents are both immigrants and raised their children on the tenants of hard work, honesty, and helping others. When Respondent was eight years old, his mother was diagnosed as terminally ill with a prognosis of 10 years to live. Due to successful medical treatment, she has survived. Respondent's brother later suffered a "brain bleed" and required life-saving surgery. Both of these events had a profound impact on Respondent and motivated him to pursue a career in medicine.

26. Respondent admits he was overwhelmed by, and unprepared for, the heavy workload when he first started the Program at Cooper. He was first assigned to the orthopaedic trauma rotation, and worked 12 to 14-hour days. When at home, he was always studying, including, reviewing pathologies he encountered that day and preparing consultations for the following day. Typically, first-year residents are paired with a senior resident (4th or 5th year); however, Respondent was supervised by a third-year resident, Stephen Turkula, M.D. Dr. Turkula did not offer much feedback in Respondent's first month.

27. Additionally, stressors in Respondent's personal life contributed to the difficulties he initially experienced at Cooper. Specifically, his father was diagnosed with lymphoma and was undergoing chemotherapy. Respondent made the seven-hour drive each weekend to visit and support his father. Also, Respondent was newly married. His wife had moved from California to Philadelphia to be with Respondent, and Respondent spent considerable time helping her settle into her new location. Respondent believes these personal issues caused him to be "spread too thin." He did not share his personal stressors with Dr. Fuller because he had been raised to keep his professional and personal lives separate. He believes these factors, combined with being in a busy hospital setting within a very small residency program, caused him to be "overwhelmed" at times and contributed to Dr. Fuller's perception that he was not meeting program expectations.

28. Respondent also believed he was unfairly targeted by his chief resident, Dr. Khatri, with whom he had an immediate personality conflict. Respondent believes Dr. Khatri held a grudge against him after Respondent refused one of his orders which conflicted with an attending physician's instruction. Respondent believes, from that point on, Dr. Khatri wanted to see him fail, spoke badly about him to Dr. Fuller and others, and highlighted minor mistakes by Respondent which were typical of first-year residents.

29. Prior to the September 30, 2016 meeting, Respondent's interaction with Dr. Fuller had been minimal. He had worked with Dr. Fuller in the operating room on one occasion, and spoken to him a handful of times. Respondent was "surprised" by the meeting; unaware he was exhibiting that many deficiencies. When Respondent asked for specific examples where he did something wrong, Dr. Fuller only told him of two incidents. The first concerned an allegation that Respondent authorized another resident to reduce a fracture by herself. Respondent denied the allegation and Dr. Fuller later confirmed it was untrue. The second involved an allegation that Respondent was watching the Olympics while on duty. Respondent denied this allegation as well.

30. Respondent did not believe the Action Plan limited the scope of what he was authorized to do regarding patient care, noting he had the same duties and responsibilities as before. Although Respondent felt he was performing better, he received weekly feedback from Drs. Fuller and Khatri which he felt was meant to penalize rather than help him. He also felt that Dr. Fuller's attitude had changed negatively toward him. When he was informed of the PIP, Respondent was "shocked," but not surprised. He was surprised when the Action Plan was supplanted by a formal PIP.

31. Respondent completed the training modules on weekends. He reviewed the written materials only, and believed the videos were optional. Respondent denied telling Dr. Fuller that he had watched the videos. He explained that when Dr. Fuller asked him if he had completed the modules, Respondent responded affirmatively and answered Dr. Fuller's questions based on the written materials. When Dr. Fuller asked him about the video, Respondent told him he did not watch the videos because he thought they were optional. Respondent apologized and said he would do both going forward. Nonetheless, Dr. Fuller accused Respondent of lying about having watched the video. Respondent denied that he ever claimed to have watched the video. Dr. Fuller then presented Respondent with two choices: (1) admit he had lied about watching the video and have a chance to continue in his residency; or (2) continue in his stance and be terminated from the Program. Feeling he had no choice, Respondent admitted to lying about having watched the video. Respondent had hoped that by admitting to it, Dr. Fuller would "give [him] a chance [and] help [him] be a good resident." Instead, from that point on, every interaction with Dr. Fuller was "skewed."

32. On December 30, 2016, Respondent filed a complaint with Cooper's human resources (HR) department, alleging that Dr. Khatri had created an environment that was not conducive to a successful residency. He further alleged that Dr. Fuller was biased against Respondent and mishandled efforts to help Respondent succeed as a resident. The HR department advised Respondent it would not intervene in disputes between residents and a chief resident or attending physician unless patient harm is a risk.

33. Respondent completed the second half of his first-year residency not subject to an Action Plan or PIP, and completed rotations in general surgery trauma, surgical intensive care, and joints service, and plastic surgery. Respondent believes he improved during the second half, learned from his past mistakes, was more open with mentors and sought their guidance. His performance evaluations from January to June 2017 bear this out, evidencing Respondent's performance was on an upward trend.

34. After he resigned; Respondent felt like he "lost his identity as a professional." He started an independent study for orthopaedic surgery and looked for a good orthopaedic surgery program. Respondent explained the Junior Specialist position at UC Davis was a one-year position, with duties equivalent to a second-year resident. He planned to use his experience there as a stepping stone to another orthopaedic residency program. He was unable to accept the position due to his lack of licensure. If he is issued a license, Respondent plans to reapply.

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35. In an undated letter to the Board, Respondent explained that he did not intend to mislead the Board when he indicated there were no limitations or special requirements placed upon him "for clinical performance, professionalism, medical knowledge, discipline, or for any other reason." When he completed the application, he did not understand that the PIP was considered a limitation or special requirement. He asserted he was "never restricted from patient treatment and continued to care for patients" as he did before the PIP. He was never placed on probation. According to Cooper's residency manual, the PIP was not disciplinary in nature. At hearing, Respondent testified that the Action Plan and PIP were intended solely to notify Respondent of his deficiencies and the consequences if he did not improve sufficiently. He maintained that they did not impose any additional requirements on his residency.

Support Testimony and Letters

36. Eric Kupersmith, M.D., is the Chief Medical Officer of the Cooper University Health System. He testified and submitted a letter on Respondent's behalf. Dr. Kupersmith met Respondent during his residency due to the fallout between Respondent and Dr. Fuller. In late November or early December, Dr. Kupersmith was asked to directly intervene because some faculty recognized Respondent as having "potential."

Dr. Kupersmith interviewed Respondent and Dr. Fuller, and gave feedback to both. Dr. Kupersmith found that Respondent had fallen behind his resident peers in the first quarter of the year, and that he had a specific issue with Dr. Fuller calling his integrity into question. Dr. Kupersmith believed Respondent performed well under the Action Plan and found nothing out of the ordinary for a trainee who was struggling.

Dr. Kupersmith described Respondent as an "industrious, intelligent, and reliable individual," who was in a challenging residency. Respondent confided in him regarding his personal stressors which had taken a toll on him emotionally and physically. Dr. Kupersmith asserted that Respondent had taken "full accountability for his actions and his situation and put forth the effort to improve." He felt that Respondent was a strong candidate for an orthopaedic residency, and that his performance issues were "on par with other trainees [he] has worked with over the years who ultimately successfully completed training programs." Dr. Kupersmith "strongly endorsed" Respondent and would expect him to succeed as an orthopaedic surgeon.

37. Michael Franco, M.D., is an Assistant Professor of Surgery in Cooper's Department of Plastic and Reconstructive Surgery. He testified and submitted a letter on Respondent's behalf. Dr. Franco met Respondent during Respondent's plastic surgery rotation. During their first case in the operating room, Dr. Franco noticed Respondent was a self-starter and prepared for the case "from start to finish." Respondent successfully completed a skin graft under Dr. Franco's supervision. Dr. Franco described Respondent as a competent and safe resident, an excellent communicator, team-oriented, and a "competent physician who conducts himself with an honest, ethical and professional manner."

38. Lawrence Miller, M.D., is Chairman of Department of Orthopaedics at Cooper. He submitted a letter on Respondent's behalf. Dr. Miller observed Respondent during his first year of residency and got to know him "very well." He acknowledged Respondent had

difficulties keeping up with the volume and work flow, struggled with time organization, and seemed overwhelmed. Dr. Miller was a source of support for Respondent and helped him improve. He noted Respondent made "excellent gains and improved in all areas." During his rotation with Dr. Miller, Respondent did an "excellent job" interviewing patients, interpreting x-rays, MRI scans, and medical records; his presentations were crisp and accurate, and his summations of the problems were on target. In Dr. Miller's opinion, Respondent was functioning on a level consistent with other first-year residents.

39. Ju-Lin Wang, M.D., is an Assistant Professor in Cooper's Department of Surgery. Dr. Wang is aware of Respondent's difficulties in the early part of his residency. Dr. Wang worked with Respondent during his rotation in Trauma Surgical Intensive Care. He described Respondent as "competent, provid[ing] good care to patients . . . honest, professional and ethical."

Discussion

40. It is undisputed Respondent struggled in the early part of his residency, and that he experienced issues with efficiency, documentation, accuracy, and consultations. Respondent's struggles continued while he was on the Action Plan and during the beginning of the PIP. However, it was evident that Respondent made some improvement toward the end of the PIP, and that his performance continued to improve during the second half of his first resident year. While Respondent was given credit for his first year, the evidence he provided in support of licensure does not provide the Board with sufficient confidence that he is safe for independent practice. Respondent's endorsements by Drs. Kupersmith, Miller, Wang, and Franco provide a strong indication that Respondent would be a successful orthopaedic surgeon with the right guidance and residency program.

41. In addition to competency issues, Respondent was dishonest when he responded "No" to Question 31 of the application, regarding whether any limitations or special requirements had been placed on him for clinical performance, professionalism, medical knowledge, discipline, or for any other reason. Honesty and integrity are essential characteristics of a licensee. Respondent's contention that he misunderstood the question and did not understand that the parameters of the PIP constituted "limitations or special requirements" was unpersuasive. As noted by Dr. Silva, Respondent was subject to extensive limitations and requirements with respect to patient care, mandatory weekly feedback meetings, scholarly assignments, and referrals to external specialists. Moreover, the PIP identified Respondent's deficiencies in several core competencies, including Professionalism and Medical Knowledge. At hearing, Respondent testified that the PIP did not place restrictions on him concerning patient care. However, Respondent's answer ignores the full scope of the question –"[w]ere any limitations or special requirements imposed on you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?" Given Respondent's vast education and credentials, it is implausible that he did not understand the import or intent of Question 31, or that the parameters of the PIP were precisely the sort of "limitations or special requirements" to which the Board was referring.

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42. Furthermore, Respondent has exhibited a pattern of dishonesty. He was found to be dishonest on multiple occasions during his residency at Cooper. Although he blamed Drs. Fuller's and Khatri's bias against him, his student records reflect that concerns regarding his honesty were widespread among other staff. Respondent was again dishonest in his application. At hearing, his excuses and explanations were unbelievable. As an example, Respondent lied to Dr. Fuller about watching the video module. In his written response to the PIP, Respondent admitted he had lied. Later, in his undated letter to the Board, Respondent described the incident as a misunderstanding between Dr. Fuller and himself. At hearing, Respondent changed his story again. He testified that he never told Dr. Fuller that he had watched the video, and that Dr. Fuller had coerced him to accept responsibility for something he did not do. As discussed earlier, Respondent's records from Cooper were replete with concerns about his honesty. "Honesty is not considered an isolated or transient behavioral act; it is more of a continuing trait of character." (*Gee v. State Personnel Board* (1970) 5 Cal.App.3d 713, 719.) While Respondent attempted to explain the discrepancies in the different stories he offered, it is not clear that he has fully learned from his mistakes and taken responsibility for his own actions and shortcomings.

LEGAL CONCLUSIONS

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Administrative proceedings before the Medical Board are not designed to punish but to afford protection to the public upon the rationale that respect and confidence of the public is merited by eliminating from the ranks of practitioners those who are dishonest, immoral, disreputable, or incompetent. (*Fahmy v. Medical Bd. of California* (1995) 38 Cal.App.4th 810, 817.)

2. Respondent bears the burden of proving that he meets all prerequisites necessary for the requested license. (Evid. Code, § 500; see also, *Martin v. Alcoholic Beverage Control Appeals Board* (1959) 52 Cal.2d 238 ["An Respondent for a license bears the burden of proving that he should be granted a license"].) Except as otherwise provided by law, the standard of proof is a preponderance of the evidence. (Evid. Code, § 115.)

Applicable Law

3. Business and Professions Code section 480, subdivision (a)(3)(A), provides that a board may deny a license on the grounds that the Respondent has done any act that if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license.

4. The Board may deny a license on the grounds the Respondent is guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license . . . ." (Bus. & Prof. Code, § 2221.) Alternatively, in its sole discretion, the Board may issue the Respondent a probationary license subject to specified terms and conditions. (*Id.*)

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5. Pursuant to Business and Professions Code section 2234, the Board "shall take action against any licensee who is charged with unprofessional conduct." Unprofessional conduct includes "incompetence" and "[t]he commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon." (Bus. & Prof. Code, § 2234, subds. (d), (e).)

Cause for Denial

6. As set forth in the Factual Findings collectively and individually, and in particular Factual Findings 5 through 15, 19 through 23, and 40, cause exists to deny Respondent's application pursuant to Business and Professions Code sections 480, subdivision (a)(3)(A), 2221, subdivision (a), 2234, subdivision (d). The term "incompetency" generally indicates "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055.) Respondent was placed on a performance improvement plan to address deficiencies in multiple core competencies. While Respondent demonstrated some improvement in the latter half of his first year residency, the evidence was insufficient to establish he possesses the qualification, ability, and fitness required for independent practice as a licensed physician.

7. As set forth in the Factual Findings collectively and individually, and in particular Factual Findings 41 and 42, cause exists to deny Respondent's application pursuant to Business and Professions Code sections 480, subdivision (a)(3)(A), 2221, subdivision (a), and 2234, subdivision (e). Respondent was dishonest in his license application wherein he represented there were no limitations or special requirements placed upon his residency.

8. While grounds exist to deny Respondent a medical license, it is within the Board's discretion to grant a probationary license with terms and conditions designed to rehabilitate Respondent, so long as public protection is not compromised in the process. (Bus. & Prof. Code, § 2229) After reading the record and considering the written and oral arguments, the Board finds that it can protect the public while allowing Respondent to continue on with his training, provided he is granted a three-year probationary license, subject to the Board's standard terms and conditions. Additionally, Respondent's first year of practice shall be performed in a supervised, ACGME-approved postgraduate training program. Moreover, under Factual Findings 26 and 27, Respondent testified, in part, that he was ill-prepared for the stress and pressure of his residency at Cooper, which contributed to his difficulties in the program. Accordingly, in addition to the standard terms and conditions of probation, Respondent will be required to undergo a stress management course/program approved by the Board to ensure he is better prepared for his next period of training and ongoing professional practice. Finally, Respondent will be required to complete a professionalism program approved by the Board to address his dishonesty.

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ORDER

Andrew Nam Cai's application for a full and unrestricted physician's and surgeon's certificate is denied. However, Respondent shall be issued a probationary license for three (3) years with the following terms and conditions:

1. Prohibited Practice

Respondent's first year of practicing medicine shall be performed in an ACGME-approved postgraduate training program. During his first year of practice, Respondent is prohibited from practicing outside of an ACGME-approved postgraduate training program.

2. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Statement of Issues, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. Stress Management Course/Program

Within 60 calendar days from the effective date of this Decision, Respondent shall enroll in a stress management course/program approved in advance by the Board or its designee. Failure to complete the entire course/program no later than six (6) months after Respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. This course/program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A stress management course/program taken after the acts that gave rise to the charges in the Statement of Issues, but prior to the effective date of the Decision may, in the sole discretion

of the Board or its designee, be accepted towards the fulfillment of this condition if the course/program would have been approved by the Board or its designee had the course/program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee no later than 15 calendar days after successfully completing the course/program, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Notification

Within seven (7) days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

6. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

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Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction

shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for an Respondent residing outside of California, will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

11. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

12. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

The Decision shall become effective at 5:00 p.m. on March 8, 2019.

IT IS SO ORDERED this 7th day of February 2019.

Ronald H. Lewis, M.D., Chair
Panel A
Medical Board of California

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Statement of Issues Against:	)	
ANDREW NAM CAI	)	Case No.: 800-2017-038695
	)	OAH No.: 2018060625
Applicant	)	

ORDER OF NON-ADOPTION OF PROPOSED DECISION

The Proposed Decision of the Administrative Law Judge in the above-entitled matter has been **non-adopted.** A panel of the Medical Board of California (Board) will decide the case upon the record, including the transcript and exhibits of the hearing, and upon such written argument as the parties may wish to submit directed at whether the proposed penalty should be modified. The parties will be notified of the date for submission of such argument when the transcript of the above-mentioned hearing becomes available.

To order a copy of the transcript, please contact Diamond Court Reporters, 1107 2nd Street #210, Sacramento, CA 95814. The telephone number is (916) 498-9288.

To order a copy of the exhibits, please submit a written request to this Board.

In addition, oral argument will only be scheduled if a party files a request for oral argument with the Board within 20 days from the date of this notice. If a timely request is filed, the Board will serve all parties with written notice of the time, date and place for oral argument. Oral argument shall be directed only to the question of whether the proposed penalty should be modified. Please do not attach to your written argument any documents that are not part of the record as they cannot be considered by the Panel. The Board directs the parties' attention to Title 16 of the California Code of Regulations, sections 1364.30 and 1364.32 for additional requirements regarding the submission of oral and written argument.

Please remember to serve the opposing party with a copy of your written argument and any other papers you might file with the Board. The mailing address of the Board is as follows:

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-3831
(916) 263-2349
Attention: Kristy Voong

Date: October 30, 2018

Ronald H. Lewis, M.D., Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Statement of Issues Against:	Case No. 800-2017-038695
ANDREW NAM CAI,	OAH No. 2018060625
Respondent.	

PROPOSED DECISION

Administrative Law Judge Tiffany L. King, Office of Administrative Hearings, State of California, heard this matter on July 10, 2018, in Sacramento, California.

David Carr, Deputy Attorney General, represented Kimberly Kirchmeyer (complainant), Executive Director of the Medical Board of California (Board), Department of Consumer Affairs, State of California.

Paul Chan, Attorney at Law, represented Andrew Cai, M.D. (respondent), who was present.

Evidence was received, the record was closed, and the matter was submitted for decision on July 10, 2018.

FACTUAL FINDINGS

1. On June 6, 2017, respondent filed an application for a physician's and surgeon's certificate with the Board. The Board denied the application on November 13, 2017. Respondent timely filed a notice of defense, requesting an administrative hearing. On March 12, 2018, complainant brought the instant Statement of Issues solely in her official capacity.

Respondent's Licensure Application

2. Question 31 on the application, concerning postgraduate training, asked: "Were any limitations or special requirements imposed on you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?" Respondent

answered, "No." He signed the application, certifying under penalty of perjury that all of the information listed therein was true and correct.

3. On or about July 3, 2017, in connection with respondent's application, the Board received a Certificate of Completion of ACGME/RCPSC[1] Postgraduate Training, completed by David A. Fuller, M.D., Program Director of the Orthopaedic Surgery Program (Program) at Cooper University Hospital (Cooper) in Camden, New Jersey. In the section entitled "Unusual Circumstances," Dr. Fuller answered "Yes" to the following question:

> Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems, or for any other reason?

In a cover letter dated June 30, 2017, Dr. Fuller explained that, during his first year at Cooper, respondent had been subject to "conditions or restrictions beyond those generally associated with the training regimen" for the Program. Dr. Fuller continued that respondent "demonstrated professional and communication deficiencies during his first six months in the program." He explained:

> . . . [Respondent] struggled with attention to detail, careful reporting of activities, time management skills and understanding the time commitment and focus required to succeed in the program. He was placed on a performance improvement plan to address these issues. Evaluations during the performance improvement plan indicated some evidence of improvement. [Respondent] concluded that he wished to pursue a different program and voluntarily resigned his position in the residency program [for second year of residency] before completion of the first year.
>
> [Respondent] did finish the [first] year with some modifications to his program, and is credited with completion of his PGY1 year. [Respondent] did demonstrate personal growth and maturation through the year.

Residency at Cooper

4. Respondent began his first year of a five-year residency program in orthopaedic surgery at Cooper on July 1, 2016. Dr. Fuller was the Program Director. Vishal Khatri, M.D., was the Chief Resident.

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[1] ACGME stands for Accreditation Council for Graduate Medical Education. RCPSC stands for Royal College of Physicians and Surgeons of Canada.

5. From the outset, respondent struggled with the rigorous demands of residency. Dr. Khatri and others expressed concerns to Dr. Fuller regarding respondent's communication, documentation, patient care, failing to discuss patient consultations with attending physicians or senior residents, failing to complete his assignments, and not seeking guidance or assistance.

6. In late August 2016, Dr. Fuller met with respondent and discussed the concerns of other residents and faculty regarding his performance, specifically respondent's ability to follow instructions and perform patient consultations. Dr. Fuller gave an example in which respondent asked for Dr. Fuller's treatment recommendation for a pediatric patient with a humerus fracture. It was evident to Dr. Fuller that respondent had neither reviewed the x-rays nor seen the patient prior to consulting with him.

ACTION PLAN

7. On September 30, 2016, Dr. Fuller again met with respondent and advised him there were continuing concerns regarding his performance. Dr. Fuller provided respondent a formal, written "Action Plan" to address these deficiencies. The Action Plan included well-defined clinical expectations, a more limited scope of practice, closer evaluation of respondent's work, and weekly feedback. It also included learning modules consisting of reading materials, videos, and other available references. Dr. Fuller advised respondent that if his performance did not improve, he risked being placed on probation, nonrenewal of his contract, and termination. The Action Plan took effect on October 3, 2016, and was to last one month.

8. Dr. Fuller and respondent next met on October 11, 2016. Dr. Fuller asked respondent if he had viewed the videos for the Splinting Module. Respondent replied that he had. Dr. Fuller then asked him specific questions about the video, including, who was the instructor, what demonstrations were shown, etc. Based on respondent's answers, Dr. Fuller concluded that respondent had not watched the video. When he confronted respondent, he asserted he had had difficulties playing the video on the computer.

9. On October 13, 2016, the Action Plan was modified due to "persistent deficiencies." Among other things, these modifications required respondent to contact a senior resident before evaluating a patient, and to review all consults with an attending physician prior to documenting the patient's medical chart.

PERFORMANCE IMPROVEMENT PLAN

10. By letter dated October 25, 2016, Dr. Fuller notified respondent that the Action Plan was being supplanted by a performance improvement plan (PIP) designed to improve his performance in one or more ACGME competencies. The letter identified academic deficiencies in six competencies (Professionalism, System Based Practice, Patient Care, Medical Knowledge, Communication, and Practice Based Learning), specifically, that respondent failed to:

(1) perform assigned tasks;
(2) follow instruction;
(3) competently perform histories and physicals, develop appropriate plans;
(4) follow through with stated work plans;
(5) triage patient care issues;
(6) work efficiently and balance multiple tasks;
(7) present consults well;
(8) document well (accuracy, timeliness);
(9) anticipate patient care needs and function proactively; and
(10) understand and acknowledge own deficiencies.

Additionally, under Professionalism, Communication, and System Based Practice, the letter characterized respondent's conduct as "Unethical Conduct – failure to speak honestly (lying)". Specific examples of respondent's academic deficiencies and alleged misconduct were attached.

Under "Interpersonal and Communication Skills Goals," the letter stated:

> In relation to all of the above, [respondent] needs to listen to advice and feedback. [Respondent] needs to speak truthfully. [Respondent] needs to stop lying. [Respondent] needs to speak clearly with others. [Respondent] needs to be accountable for his actions and to learn to answer with a yes or no when asked direct questions. [Respondent] needs to communicate better with his supervising senior residents and faculty.

Under "Professionalism Goals," the letter provided:

> In relation to all of the above, [respondent] needs to behave as a person that cares about what he is doing. He needs to work with integrity. He needs to understand that his failings have direct impact upon patients. He needs to take responsibility for his actions. He needs to learn to apologize. He needs to learn to stop making excuses. He needs to document his performance activities in a truthful, timely and thorough manner. [Respondent] must respond to communications from his faculty and administrators in a timely fashion.

11. The letter also identified a "Plan of Remediation," which included "scholarly assignments, a restricted scope of practice with limited patient care expectations to preserve patient safety and regular feedback." Additionally, respondent was to meet with external specialists, including a learning specialist and work performance counselors.

12. The letter advised that respondent would be placed on the PIP for 60 days, beginning November 1, 2016. At the conclusion of the PIP, a decision would be made concerning respondent's continued participation in the residency program and employment at Cooper. Finally, the letter noted, "[t]his decision may involve successful completion of the PIP and continuation in the program, continuation in the program on probationary status, suspension or termination (dismissal)."

13. Respondent submitted a written response to the PIP on or about October 31, 2016. In it, respondent admitted to exhibiting deficiencies in triaging patient care, presentation of patient consultations, efficiency, and multi-tasking. He disagreed with the remaining identified deficiencies. In addition, he refuted the notion that he was generally dishonest. However, he admitted that he had not watched the training videos and nonetheless implied to Dr. Fuller that he had. He also acknowledged communicating inaccurate information to his team; however, he denied any intent to lie or deceive. Rather, he explained, "[a]fter self-reflecting my time at Cooper, I found that I was not able to recall information correctly due to my lack of organization and focus (not deception)."

14. While the PIP remained in effect, communications between faculty and Dr. Fuller evidenced ongoing concerns regarding respondent's adherence to the requirement he consult with an attending physician prior to documenting care in a patient's medical chart. In a December 5, 2016 note, Dr. Fuller described an incident reported to him in which respondent verbally asserted he had consulted with the attending physician prior to documenting the chart; however, his chart note made no reference to having consulted an attending physician. The attending physician also had no recollection of discussing the patient with respondent. Dr. Fuller concluded, " . . . [a]ll evidence suggests that [respondent] is lying again."

15. Evaluations of respondent's performance immediately prior to and during the PIP indicated some improvement. For instance, one reviewer noted that respondent had "struggled early . . . but has improved the last 2 weeks." Another reviewer commented that, during his vascular surgery rotation, respondent was "attentive and focused" and "[f]it in well with our team." Still, other evaluators remained concerned about respondent's work ethic, honesty, and ability to perform at the level expected of first-year residents. One reviewer commented that respondent "[needs] to work harder. Has lost trust of fellow residents. Needs to work harder to regain trust of the team." Another reviewer noted on December 27, 2016:

> [Respondent] was a friendly intern who came to work with a good attitude. He appeared to have significant deficits with regards to his general understanding of his duties. His level of function was closer to a starting intern than a seasoned one in mid-year form. He frequently required significant guidance for basic floor tasks and the senior residents and fellows felt the need to prioritize his daily tasks in order to assure that the most pressing issues were completed in a timely fashion.

16. Respondent completed the PIP on December 31, 2016. The PIP was not renewed and respondent returned to his normal resident schedule. On February 20, 2017, respondent informed Dr. Fuller of his intent to resign after the completion of his first residency year with credit and to not return for his second year.

17. Respondent completed the remainder of his first year residency without incident. His performance evaluations were mixed, but overall reflected that respondent's maturity and confidence had grown, and his efficiency improved. Respondent received credit for 12 months of postgraduate residency training, and thereafter voluntarily resigned from the Program.[2]

UC Davis Job Offer

18. After resigning from the Program, respondent and his wife relocated to California. In August 2017, respondent was offered a non-ACGME accredited Junior Specialist position in the Department of Orthopedic Surgery at UC Davis Medical Center. As described by respondent, his role would be "to act as an attending hospitalist and consultant for incoming ER patients during daytime hours for the Orthopaedic Trauma Service" and provide a physician presence in the emergency room and Orthopaedic Surgical Intensive Care Unit. The position requires respondent to have a valid California medical license.

Joseph Silva, M.D.

19. Complainant called Joseph Silva, M.D., as an expert witness. Dr. Silva has been licensed to practice medicine in California since 1983. Previously, he was licensed to practice medicine in Maryland (1968-1969) and Michigan (1969-1983). He has been board-certified in internal medicine since 1972. From 1972 to 1985, Dr. Silva served as the Program Director of Internal Medicine at the University of Michigan Medical School, overseeing more than 140 residents and 100 post-doctoral fellows. Thereafter, he was a professor and Chairman of Medicine at the University of California, Davis (UC Davis) for 15 years, teaching internal medicine and family medicine. In 1997, he became the Dean of the UC Davis School of Medicine and Chief Executive Officer of the UC Davis Health Systems. In 2005, Dr. Silva stepped down as Dean and became a dean emeritus, periodically teaching internal medicine and infectious diseases. Over the course of his career, Dr. Silva has performed functions similar to those of the Program Director of Cooper. He has had extensive opportunities to evaluate residents and to prepare performance evaluation reports on residents, which are structured to address ACGME's core competencies. In 2010, Dr. Silva was a consultant to California Northstate University to establish a new medical school. From 2015 to present, he has served as the Founding Dean, Vice President for Medical Affairs, and Professor of California Northstate University, College of Medicine. Since 2010, Dr. Silva has served as a medical consultant to the Board.

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[2] There was no evidence to suggest that respondent's resignation was offered in exchange for leaving the program and/or receiving full credit for his first year residency.

20. At the Board's request, Dr. Silva reviewed respondent's license application as well as the transcripts and certification of his medical education. Dr. Silva also reviewed the Certificate of Completion of ACGME/RCPSC Postgraduate Training completed by Dr. Fuller, and records from respondent's participation in the Program at Cooper. Based on these records, Dr. Silva noted that respondent "had a number of problems in learning that subspecialty and demonstrating performance satisfactory to a number of faculty," and that those difficulties continued while respondent was on the Action Plan and PIP.

21. Dr. Silva explained it was not unusual for a resident who was successful in medical school to be unsuccessful in residency or post-graduate program. He noted that residents are subject to a greater level of scrutiny than medical students. If there are deficiencies in a resident's performance, the program will develop an action plan, PIP, or probation plan to overcome them. Such plans are often successful. Dr. Silva explained, "these are good people, intelligent, capable, but not putting it all together." Still, there were very few programs in the country where one can become licensed after completing just one year of residency.

22. Dr. Silva noted that respondent's Action Plan and PIP at Cooper comprised a multi-prong approach to help respondent gain the necessary skills to advance. This included: limiting his scope of patient practice; requiring respondent to meet weekly with faculty for feedback, when the standard is monthly; meeting with specialists; scholarly assignments; and, "over a hundred pages of deliberations and evaluation materials by the program director and his faculty in documenting new and/or chronic performance deficiencies." Dr. Silva opined that the PIP was "sequentially designed" to give respondent "less independence in patient care decisions . . . and greater supervision because he had failed to meet training expectations on multiple occasions."

23. Dr. Silva reviewed the academic deficiencies in core competencies as identified in the PIP, and opined that these deficiencies would "hinder a doctor's ability to render effective and safer care to patients." Dr. Silva did not render an opinion regarding the allegations of dishonesty, but noted that faculty had raised concerns about respondent's truthfulness more than once. Dr. Silva further noted that, while respondent was credited for one year of training, he did so with "conditions or restrictions beyond those generally associated with the training program at that facility." Based on this, Dr. Silva opined that respondent "has multiple deficiencies in rendering safe and effective care . . . [and] has not demonstrated he has mastered the basic essentials and proficiencies required of all physicians to practice medicine."

Respondent's Evidence

24. Respondent graduated from Tufts University, earning a bachelor's degree in chemistry in 2008, and a master's degree in biomedical sciences in 2011. He obtained his a doctorate in medicine from Albany Medical College in 2016. He is not currently licensed as a physician in any state.

25. Respondent's parents are both immigrants and raised their children on the tenants of hard work, honesty, and helping others. When respondent was eight years old, his mother was diagnosed as terminally ill with a prognosis of 10 years to live. Due to successful medical treatment, she has survived. Respondent's brother later suffered a "brain bleed" and required life-saving surgery. Both of these events had a profound impact on respondent and motivated him to pursue a career in medicine.

26. Respondent admits he was overwhelmed by, and unprepared for, the heavy workload when he first started the Program at Cooper. He was first assigned to the orthopaedic trauma rotation, and worked 12 to 14-hour days. When at home, he was always studying, including, reviewing pathologies he encountered that day and preparing consultations for the following day. Typically, first-year residents are paired with a senior resident (4th or 5th year); however, respondent was supervised by a third-year resident, Stephen Turkula, M.D. Dr. Turkula did not offer much feedback in respondent's first month.

27. Additionally, stressors in respondent's personal life contributed to the difficulties he initially experienced at Cooper. Specifically, his father was diagnosed with lymphoma and was undergoing chemotherapy. Respondent made the seven-hour drive each weekend to visit and support his father. Also, respondent was newly married. His wife had moved from California to Philadelphia to be with respondent, and respondent spent considerable time helping her settle into her new location. Respondent believes these personal issues caused him to be "spread too thin." He did not share his personal stressors with Dr. Fuller because he had been raised to keep his professional and personal lives separate. He believes these factors, combined with being in a busy hospital setting within a very small residency program, caused him to be "overwhelmed" at times and contributed to Dr. Fuller's perception that he was not meeting program expectations.

28. Respondent also believed he was unfairly targeted by his chief resident, Dr. Khatri, with whom he had an immediate personality conflict. Respondent believes Dr. Khatri held a grudge against him after respondent refused one of his orders which conflicted with an attending physician's instruction. Respondent believes, from that point on, Dr. Khatri wanted to see him fail, spoke badly about him to Dr. Fuller and others, and highlighted minor mistakes by respondent which were typical of first-year residents.

29. Prior to the September 30, 2016 meeting, respondent's interaction with Dr. Fuller had been minimal. He had worked with Dr. Fuller in the operating room on one occasion, and spoken to him a handful of times. Respondent was "surprised" by the meeting; unaware he was exhibiting that many deficiencies. When respondent asked for specific examples where he did something wrong, Dr. Fuller only told him of two incidents. The first concerned an allegation that respondent authorized another resident to reduce a fracture by herself. Respondent denied the allegation and Dr. Fuller later confirmed it was untrue. The second involved an allegation that respondent was watching the Olympics while on duty. Respondent denied this allegation as well.

30. Respondent did not believe the Action Plan limited the scope of what he was authorized to do regarding patient care, noting he had the same duties and responsibilities as before. Although respondent felt he was performing better, he received weekly feedback from Drs. Fuller and Khatri which he felt was meant to penalize rather than help him. He also felt that Dr. Fuller's attitude had changed negatively toward him. When he was informed of the PIP, respondent was "shocked," but not surprised. He was surprised when the Action Plan was supplanted by a formal PIP.

31. Respondent completed the training modules on weekends. He reviewed the written materials only, and believed the videos were optional. Respondent denied telling Dr. Fuller that he had watched the videos. He explained that when Dr. Fuller asked him if he had completed the modules, respondent responded affirmatively and answered Dr. Fuller's questions based on the written materials. When Dr. Fuller asked him about the video, respondent told him he did not watch the videos because he thought they were optional. Respondent apologized and said he would do both going forward. Nonetheless, Dr. Fuller accused respondent of lying about having watched the video. Respondent denied that he ever claimed to have watched the video. Dr. Fuller then presented respondent with two choices: (1) admit he had lied about watching the video and have a chance to continue in his residency; or (2) continue in his stance and be terminated from the Program. Feeling he had no choice, respondent admitted to lying about having watched the video. Respondent had hoped that by admitting to it, Dr. Fuller would "give [him] a chance [and] help [him] be a good resident." Instead, from that point on, every interaction with Dr. Fuller was "skewed."

32. On December 30, 2016, respondent filed a complaint with Cooper's human resources (HR) department, alleging that Dr. Khatri had created an environment that was not conducive to a successful residency. He further alleged that Dr. Fuller was biased against respondent and mishandled efforts to help respondent succeed as a resident. The HR department advised respondent it would not intervene in disputes between residents and a chief resident or attending physician unless patient harm is a risk.

33. Respondent completed the second half of his first-year residency not subject to an Action Plan or PIP, and completed rotations in general surgery trauma, surgical intensive care, and joints service, and plastic surgery. Respondent believes he improved during the second half, learned from his past mistakes, was more open with mentors and sought their guidance. His performance evaluations from January to June 2017 bear this out, evidencing respondent's performance was on an upward trend.

34. After he resigned, respondent felt like he "lost his identity as a professional." He started an independent study for orthopaedic surgery and looked for a good orthopaedic surgery program. Respondent explained the Junior Specialist position at UC Davis was a one-year position, with duties equivalent to a second-year resident. He planned to use his experience there as a stepping stone to another orthopaedic residency program. He was unable to accept the position due to his lack of licensure. If he is issued a license, respondent plans to reapply.

35. In an undated letter to the Board, respondent explained that he did not intend to mislead the Board when he indicated there were no limitations or special requirements placed upon him "for clinical performance, professionalism, medical knowledge, discipline, or for any other reason." When he completed the application, he did not understand that the PIP was considered a limitation or special requirement. He asserted he was "never restricted from patient treatment and continued to care for patients" as he did before the PIP. He was never placed on probation. According to Cooper's residency manual, the PIP was not disciplinary in nature. At hearing, respondent testified that the Action Plan and PIP were intended solely to notify respondent of his deficiencies and the consequences if he did not improve sufficiently. He maintained that they did not impose any additional requirements on his residency.

Support Testimony and Letters

36. Eric Kupersmith, M.D., is the Chief Medical Officer of the Cooper University Health System. He testified and submitted a letter on respondent's behalf. Dr. Kupersmith met respondent during his residency due to the fallout between respondent and Dr. Fuller. In late November or early December, Dr. Kupersmith was asked to directly intervene because some faculty recognized respondent as having "potential."

Dr. Kupersmith interviewed respondent and Dr. Fuller, and gave feedback to both. Dr. Kupersmith found that respondent had fallen behind his resident peers in the first quarter of the year, and that he had a specific issue with Dr. Fuller calling his integrity into question. Dr. Kupersmith believed respondent performed well under the Action Plan and found nothing out of the ordinary for a trainee who was struggling.

Dr. Kupersmith described respondent as an "industrious, intelligent, and reliable individual," who was in a challenging residency. Respondent confided in him regarding his personal stressors which had taken a toll on him emotionally and physically. Mr. Kupersmith asserted that respondent had taken "full accountability for his actions and his situation and put forth the effort to improve." He felt that respondent was a strong candidate for an orthopaedic residency, and that his performance issues were "on par with other trainees [he] has worked with over the years who ultimately successfully completed training programs." Dr. Kupersmith "strongly endorsed" respondent and would expect him to succeed as an orthopaedic surgeon.

37. Michael Franco, M.D., is an Assistant Professor of Surgery in Cooper's Department of Plastic and Reconstructive Surgery. He testified and submitted a letter on respondent's behalf. Dr. Franco met respondent during respondent's plastic surgery rotation. During their first case in the operating room, Dr. Franco noticed respondent was a self-starter and prepared for the case "from start to finish." Respondent successfully completed a skin graft under Dr. Franco's supervision. Dr. Franco described respondent as a competent and safe resident, an excellent communicator, team-oriented, and a "competent physician who conducts himself with an honest, ethical and professional manner."

38. Lawrence Miller, M.D., is Chairman of Department of Orthopaedics at Cooper. He submitted a letter on respondent's behalf. Dr. Miller observed respondent during his first year of residency and got to know him "very well." He acknowledged respondent had difficulties keeping up with the volume and work flow, struggled with time organization, and seemed overwhelmed. Dr. Miller was a source of support for respondent and helped him improve. He noted respondent made "excellent gains and improved in all areas." During his rotation with Dr. Miller, respondent did an "excellent job" interviewing patients, interpreting x-rays, MRI scans, and medical records; his presentations were crisp and accurate, and his summations of the problems were on target. In Dr. Miller's opinion, respondent was functioning on a level consistent with other first-year residents.

39. Ju-Lin Wang, M.D., is an Assistant Professor in Cooper's Department of Surgery. Dr. Wang is aware of respondent's difficulties in the early part of his residency. Dr. Wang worked with respondent during his rotation in Trauma Surgical Intensive Care. He described respondent as "competent, provid[ing] good care to patients . . . honest, professional and ethical."

Discussion

40. It is undisputed respondent struggled in the early part of his residency, and that he experienced issues with efficiency, documentation, accuracy, and consultations. Respondent's struggles continued while he was on the Action Plan and during the beginning of the PIP. However, it was evident that respondent made some improvement toward the end of the PIP, and that his performance continued to improve during the second half of his first resident year. He successfully completed his first year for which he received full credit, though he did not successfully complete the Program. Respondent's endorsements by Drs. Kupersmith, Miller, Wang, and Franco provide a strong indication that respondent would be a successful orthopaedic surgeon with the right guidance and residency program. If the Board's licensure denial was based solely on a charge of incompetence, it is likely that respondent would have met his burden of establishing his fitness for a probationary license.

41. However, respondent was dishonest when he responded "No" to Question 31 of the application, regarding whether any limitations or special requirements had been placed on him for clinical performance, professionalism, medical knowledge, discipline, or for any other reason. Honesty and integrity are essential characteristics of a licensee. Respondent's contention that he misunderstood the question and did not understand that the parameters of the PIP constituted "limitations or special requirements" was unpersuasive. As noted by Dr. Silva, respondent was subject to extensive limitations and requirements with respect to patient care, mandatory weekly feedback meetings, scholarly assignments, and referrals to external specialists. Moreover, the PIP identified respondent's deficiencies in several core competencies, including Professionalism and Medical Knowledge. At hearing, respondent testified that the PIP did not place restrictions on him concerning patient care. However, respondent's answer ignores the full scope of the question –"[w]ere any limitations or special requirements imposed on you for clinical performance, professionalism, medical knowledge, discipline, or for any other reason?" Given respondent's vast education and credentials, it is

implausible that he did not understand the import or intent of Question 31, or that the parameters of the PIP were precisely the sort of "limitations or special requirements" to which the Board was referring.

42. Furthermore, respondent has exhibited a pattern of dishonesty. He was found to be dishonest on multiple occasions during his residency at Cooper. Although he blamed Drs. Fuller's and Khatri's bias against him, his student records reflect that concerns regarding his honesty were widespread among other staff. Respondent was again dishonest in his application. At hearing, his excuses and explanations were unbelievable. As an example, respondent lied to Dr. Fuller about watching the video module. In his written response to the PIP, respondent admitted he had lied. Later, in his undated letter to the Board, respondent described the incident as a misunderstanding between Dr. Fuller and himself. At hearing, respondent changed his story again. He testified that he never told Dr. Fuller that he had watched the video, and that Dr. Fuller had coerced him to accept responsibility for something he did not do. As discussed earlier, respondent's records from Cooper were replete with concerns about his honesty. "Honesty is not considered an isolated or transient behavioral act; it is more of a continuing trait of character." (*Gee v. State Personnel Board* (1970) 5 Cal.App.3d 713, 719.) Respondent needs to learn from his mistakes and start taking full responsibility for his own actions and shortcomings. To date, he has not done so.

43. When the evidence is considered as a whole, respondent has not met his burden of establishing his competency to practice medicine or his truthfulness to practice as a medical professional. At this time, his application for medical licensure should be denied.

LEGAL CONCLUSIONS

1. The purpose of the Medical Practice Act is to assure the high quality of medical practice. (*Shea v. Bd. of Medical Examiners* (1978) 81 Cal.App.3d 564, 574.) Administrative proceedings before the Medical Board are not designed to punish but to afford protection to the public upon the rationale that respect and confidence of the public is merited by eliminating from the ranks of practitioners those who are dishonest, immoral, disreputable, or incompetent. (*Fahmy v. Medical Bd. of California* (1995) 38 Cal.App.4th 810, 817.)

2. Respondent bears the burden of proving that he meets all prerequisites necessary for the requested license. (Evid. Code, § 500; see also, *Martin v. Alcoholic Beverage Control Appeals Board* (1959) 52 Cal.2d 238 ["An applicant for a license bears the burden of proving that he should be granted a license"].) Except as otherwise provided by law, the standard of proof is a preponderance of the evidence. (Evid. Code, § 115.)

Applicable Law

3. Business and Professions Code section 480, subdivision (a)(3)(A), provides that a board may deny a license on the grounds that the applicant has done any act that if done by a licentiate of the business or profession in question, would be grounds for suspension or revocation of license.

4. The Board may deny a license on the grounds the applicant is guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license . . . ." (Bus. & Prof. Code, § 2221.) Alternatively, in its sole discretion, the Board may issue the applicant a probationary license subject to specified terms and conditions. (*Id.*)

5. Pursuant to Business and Professions Code section 2234, the Board "shall take action against any licensee who is charged with unprofessional conduct." Unprofessional conduct includes "incompetence" and "[t]he commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon." (Bus. & Prof. Code, § 2234, subds. (d), (e).)

Cause for Denial

6. As set forth in the Factual Findings as a whole, cause exists to deny respondent's application pursuant to Business and Professions Code sections 480, subdivision (a)(3)(A), 2221, subdivision (a), 2234, subdivision (d). The term "incompetency" generally indicates "an absence of qualification, ability or fitness to perform a prescribed duty or function." (*Kearl v. Bd. of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1055.) Respondent failed to complete his five-year orthopaedic residency program at Cooper. He was placed on a performance improvement plan to address deficiencies in multiple core competencies. While respondent demonstrated some improvement in the latter half of his first year residency, the evidence was insufficient to establish he possesses the qualification, ability, and fitness required of a licensed physician.

7. As set forth in the Factual Findings as a whole, and in particular Factual Findings 41 and 42, cause exists to deny respondent's application pursuant to Business and Professions Code sections 480, subdivision (a)(3)(A), 2221, subdivision (a), and 2234, subdivision (e). Respondent was dishonest in his license application wherein he represented there were no limitations or special requirements placed upon his residency.

8. As set forth in Factual Finding 43, respondent has not met his burden of establishing that his application for medical licensure should be granted.

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ORDER

The application of Andrew Nam Cai for a Physician's and Surgeon's certificate is DENIED.

DATED: August 9, 2018

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TIFFANY L. KING
Administrative Law Judge
Office of Administrative Hearings